Section 86-1.38 Alternative reimbursement method for mergers or consolidations. As used in this section, the term merger shall mean the ~~combining of two or more~~ medical facilities, licensed under article 28 of the Public Health law, where such combination is consistent with the public need, would create a new, more economical entity, reduce the costs of operation, result in the reduction of beds and/or improve service delivery. The provisions of this section shall apply only if facilities seek an alternative reimbursement mechanism to complete the merger. Otherwise, reimbursement for merged facilities will be consistent with all other provisions of this Subpart.

(a) Application for merger. A merger shall meet all of the following qualifying criteria and conditions:

(1) There is a demonstrated public need for the existing hospital service in whole or in part at the current site(s) of the applicant. The determination of public need shall be made pursuant to section 2802 of the Public Health Law and in accordance with Part 709 of this Title.

(2) The application must include a demonstration of overall financial savings that can be obtained within three years from the date of inception. This projection of savings should demonstrate reduction of overall costs for the separate entities, and reduction of gross reimbursement based on costs from third-party payors due primarily to reduction in beds or services.

(3) The medical facilities must demonstrate that adequate health care services are and will be provided; that conformity with the State Hospital Code is, and will be, maintained, and an approved plan of correction for any operational and structural deficiencies in accordance with State Hospital Code has been filed.

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(b) In order to meet the requirements of paragraph (a)(2) of this section, the facility(s) must submit to the commissioner a plan of merger. This plan should include, but not be limited to:

(1) a description and composition of the proposed governing structure of the facilities submitting the applications;

(2) the development of a market analysis of the population being served;

(3) development of a functional consolidation of services, outlining:

(i) changes in the size and scope of the medical staff organization;

(ii) clinic and outpatient activities;

(iii) the integration of such areas as administration, operation of plant, laboratory, X-ray, therapies, for example;

(iv) redeployment of existing employees and future labor practices; and

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(v) such other information as the commissioner may require;

(4) a financial plan which provides for:

(i) expected changes in revenues and expenditures due to the actions to be taken by the facilities. This shall be presented in the form of a projected budget for the merged entity and shall include complete budgeted uniform statistical and financial reports; and

(ii) projected changes in salaries, fringe and union benefits;

(5) a capital plan which outlines expected capital outlays necessary to effectuate the planned merger; and

(6) changes in the quality and volume of health services to be provided as a result of the planned merger.

(c) Operating and capital costs reimbursement. Reimbursement under the provisions of this section for mergers meeting the requirements of subdivision (a) of this section shall be determined as follows and shall be for a period not to exceed three years from the date of approval of formal corporate merger of the involved facilities. Following a review of the budgeted statistical and financial data submitted by the facilities, the commissioner shall develop a new group for the merged institution, excluding the projected costs and statistics of the merged institution. All applicable ceilings shall be calculated as required by this Subpart.

(1) Mergers with ceiling penalties. In the event that the merged institution incurs ceiling penalties, the commissioner may waive these penalties for the first full year of operation under the merger. In the second year of operation, facility rates will be the initial approved base year budgeted costs and statistics reduced by an amount that is no less than one third of the amount waived in the first year, increased by the trend factor into the current rate period. In the third year of operation, facility rates will be the initial approved base year budgeted costs and statistics reduced by an amount that is no less than two thirds of the amount waived in the first year, increased by the trend factor into the current rate period.

(2) Mergers without ceiling penalties. In the event that the merged institution incurs no ceiling penalties, rates during the first year of operation will be determined by taking the approved budgeted costs and statistics increased by the appropriate trend factor into the current rate period. In the second year of operation, facility rates will be the initial approved budgeted costs and statistics increased by the appropriate trend factor into the current rate period less two percent. In the third year of operation, facility rates will be the initial approved base year budgeted costs and statistics increased by the appropriate trend factor into the current rate period less four percent.

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(3) Facilities reimbursed under this section will not be eligible for waiver of ceiling penalties in the fourth year of operation as a merged facility. In the fourth year, the facility's reimbursement rate will be based on budgeted costs for the immediately preceding year subject to the standard Part 86 methodology applicable in the fourth year. In all years subsequent to the fourth year, actual base year costs of the facility will be subjected to the standard Part 86 methodology applicable at the time.

(d) Capital Reimbursement. Capital costs associated with a closure of a facility as part of an approved plan under this section will be reimbursable to the new, merged entity subject to appropriate Federal wavier.

(e) Upon application to the commissioner, a volume adjustment as specified in section 86-1.12 of this Subpart may be implemented.

(f) Where a facility(s) covered under this Subpart demonstrates to the commissioner, subsequent to its initial participation in this Subpart, that a deviation from the original approved plan and budget will provide a more cost effective result, a new plan and budget that has been approved by the commissioner will be accepted and utilized in formulation of revised reimbursement rates for the remaining time of participation in this Subpart.

(g) Annual report. Each year a facility(s) covered under this Subpart must demonstrate to the commissioner the cost savings arising from the improved efficiencies and more effective delivery of care due to the merger, consolidation or closure of the facilities participating in the plan. This report should reflect the objectives outlined in the approved plan and be issued by the governing authority of the facilities participating.

(h) Termination of facility(s) participation. Reimbursement under this section shall terminate if:

(1) the facility deviates from its plan of merger without written approval of the commissioner;

(2) the facility fails to continue to meet the criteria delineated in this section; or

(3) three years have passed from the date of certification of the rate established pursuant to this section.

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86-1.39 [Workers' compensation and not fault reimbursement rates.] Reserved

Section 86-1.40 Alternative reimbursement method for medical facilities with extended phase-in periods. The current reimbursement system may not enable new or substantially changed facilities which require an extended start-up period to proceed in a financially viable manner and, therefore, the following alternative reimbursement method is established to insure that needed and qualifying medical facilities can develop.

(a) Facilities which apply for alternative reimbursement under this section must demonstrate that the following qualifying criteria have been met:

(1) The commissioner is satisfied that adequate health care services are and will be provided by the facility.

(2) There has been a finding by the commissioner that the projected expansion and phase-in of the medical facility is appropriate and in the public interest.

(3) Pursuant to a plan of construction or expansion, approved by the commissioner, the facility will either be opening as a new facility or opening additional beds, commencing additional services, or projecting staffing increases.

(4) The facility can demonstrate to the satisfaction of the commissioner that its staffing and operational costs will, by the end of its approved transition period, be within acceptable staffing guidelines and capable of operating under the standard reimbursement methodology.

(5) The facility must demonstrate that it meets the criteria of a new facility or the criteria set forth in paragraph (4) of section 86-1.17 of this Subpart. A new facility is defined as one that has had no previous cost experience and no previous operating certificate.

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(6) There are such other related indications of substantial changes as the commissioner may specify.

(b) Facilities which apply for alternative reimbursement under this section will be required to submit, subject to the approval of the commissioner, the following information at least 60 days prior to the start of the alternative reimbursement period:

(1) a market analysis of the population to be served;

(2) an organization description of the hospital, including a description of the medical staff organization and composition of the governing body;

(3) a detailed plan of the phase-in of routine and ancillary services, beds, staffing levels and expected utilization by major program area during the phase-in period in a manner prescribed by the commissioner;

(4) a detailed transitional financial plan which reflects anticipated revenues, including annual tax levy support and expenditures during the phase-in period, including a facility

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budget which reflects planned services expansion as described in paragraph (b)(3) of this section. If requested by the commissioner, the facility shall provide a line item budget with respect to staffing and personnel, and such detail as prescribed by the commissioner for other than personal service items, including capital.

(c) A facility which meets the criteria and informational requirements in subdivisions (a) and (b) of this section, and has received the commissioner's approval of its detailed transitional financial plan, shall have the operating and capital components of its rate established as follows:

(1) A reimbursement rate established under this section shall only be for a time period as approved in the facility's submitted plan, but no greater than five years.

(2) The capital cost component of the rate for each year of the plan will be based on approved annual budgeted cost, divided by the approved targeted patient volume for the rate year and retrospectively adjusted to actual certified cost.

(3) The operating component of the rate will be determined based on an approved budget subject to the following limitations and adjustments:

(i) Changes in personal service and nonpersonal service costs from the base period to the rate period shall be limited to the same factors for inflation which affect the hospital industry, except that costs associated with the phase-in of beds, programs and services which were not existent in a previous period will be allowed, subject to the review and approval of their incremental costs.

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(ii) For each year in transition, a peer group will be simulated for the facility. The simulation will be based on the facility's approved budget and phase-in statistics for the facility. The operating component of the reimbursement rate will be subjected to a maximum of the peer group ceiling increased by no greater than five percent times the remaining years of the transition period.

(iii) If the facility's volume is below the approved target volume, no adjustment shall be made.

(iv) If the facility's volume is above the approved targeted volume by five percent, the facility will be submitted to a volume adjustment to adjust their rate over the approved target for incremental costs.

(v) The hospital will be expected to meet the length of stay standards specified in section 86-1.17 of this Subpart.

(vi) The rates established under this section shall be prospective and be subject to adjustment and audit. A length of stay penalty, utilization penalty and volume adjustment

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may be implemented in the year succeeding the rate period in which the respective requirements are not met.

(d) Reimbursement under this section shall terminate if:

(1) the facility significantly deviates from its approved plan without the written approval of the commissioner;

(2) the facility fails to continue to meet the criteria delineated in this section;

(3) the facility requests to withdraw from this program with the understanding that participation in subsequent rate years is prohibited.

(e) The effective date of the reimbursement rate established pursuant to this section shall be the day on which Federal approval is effective.

86-1.41 [Hospital-based ambulatory surgery rates.] Reserved

Section 86-1.42 Hospital-based Physician Reimbursement Program.
(a) Definitions. As used in this section:

(1) Physician shall mean hospital-based supervisory and other salaried physicians, excluding interns and residents.

(2) Fringe benefits shall mean fringe benefits required by law, plus health, welfare, retirement, and educational benefits given in lieu of direct compensation.

(3) Total physician compensation shall mean the prospectively set base year compensation for physicians responsible for a service or department plus a fringe benefit allowance not to exceed 25 percent of the base year compensation, less any portion of that compensation which is for other than that service or department.

(4) Total employee staff compensation shall mean the prospectively set base year compensation for nonphysician employees assigned to a service or department, plus a fringe benefits allowance, less any portion of that compensation which is for other than that service or department.

(b) Notwithstanding any other provision of this Subpart, allowable reimbursable costs for physicians responsible for the inpatient diagnostic and therapeutic services or departments of radiology, radiation therapy, ultrasonography, laboratory medicine and pathology, nuclear medicine, electrocardiography and hospital cardiology services, exclusive of cardiac catheterization, shall be 104 percent of total physician and employee staff compensation for each of these services. Allowable reimbursable costs for physicians responsible for clinical laboratory services shall be 103 percent of total physician and employee staff compensation for such services. Reimbursement paid pursuant to this subdivision in excess of actual salaries, fringe benefits, and incentive payments, if any, shall be called professional development funds. These funds shall be distributed by the hospital among the clinical laboratory service and the aforementioned inpatient diagnostic and therapeutic services and departments. These funds shall be considered departmental funds and may be used to improve the clinical care of patients receiving services from the department, to enhance or supplement the department's educational program, and for purchases of hospital patient care equipment. These funds shall be committed annually.

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(c) Notwithstanding any other provision of this Subpart, hospitals shall be reimbursed for the cost of a single adjustment to total physician compensation for physicians who are responsible for the inpatient diagnostic and therapeutic services or departments of radiology, radiation therapy, ultrasonography, laboratory medicine including all clinical laboratories and pathology, nuclear medicine, electrocardiography and hospital cardiology services exclusive of cardiac catheterization, provided that the overall compensation for such physicians in aggregate does not exceed the 80th percentile as reported in the American Association of Medical Colleges faculty compensation survey for the base year. This adjustment shall be in an amount sufficient to provide funds for overall compensation of such physicians in the aggregate equivalent to the 80th percentile as reported in the survey. The cost of such adjustment in excess of the

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limitation on allowable costs for such services as set forth in section 86-1.14(c) of this Subpart shall be excluded from the calculation of base period costs and shall be reimbursed.

(d) The provisions of this section shall apply only to those hospitals:

(1) which apply to the commissioner for participation in this program within six months of the effective date of this section;

(2) which have a written agreement with their physicians which specifies physician responsibility with regard to scope of service and education of all physicians on the prudent use of diagnostic services and which specifies productivity and utilization standards for all departments to reduce unit costs of services;

(3) which document a fixed prospective physician compensation arrangement set in advance of the rate year, which may include an incentive plan provided such plan does not exceed 15 percent of the aggregate prospective base compensation and provided such plan has been approved by the commissioner upon a showing by the hospital that incentive plan costs will be offset by equivalent productivity gains and cost savings; and

(4) which, following the first year of participation in the program, document annually an appreciable reduction in unit costs of services as a result of participation in the program.

(e) This section shall be contingent upon Federal financial participation.